

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

094180

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		
3. NAME OF DECEASED (Type or print) Russell A		d. STREET ADDRESS Rt. 1, Box 437		
4. DATE OF DEATH Sept. 19, 1957		Month Sept.	Day 19	
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Mar. 13, 1885		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Special Police	11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Parker Allen		
14. MOTHER'S MAIDEN NAME Sallie Hardwick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn A. Henkel, Accokeek, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Carcinoma of urinary bladder (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 14 Sept., 1957, to 19 Sept., 1957, that I last saw the deceased alive on 18 Sept., 1957, and that death occurred at 7:45 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE V. B. Dettor		ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 19 Sept. 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-57	22c. NAME OF CEMETERY OR CREMATORIUM Glenwood	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, 517 - 11th St. S. E., D. C.		24a. REC'D BY REGISTRAR DATE 9/19/57		24b. REGISTRAR'S SIGNATURE Julia H. Pasen

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
BUREAU V. S.				
SEP 24 1957				
RECEIVED				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09411
Reg. Dist. No. 100

Item 8- *Death Party cert - Mo*

1. PLACE OF DEATH a. COUNTY <i>Charles</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>					
MARYLAND	b. COUNTY <i>Charles</i>					
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO La Plata, Md</i>					
c. LENGTH OF STAY IN lb <i>10 days</i>	d. STREET ADDRESS <i>1217 Main St</i>					
8. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kingman Hosp</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>James Edward BEAN</i>	4. DATE OF DEATH 9 Month Day Year <i>12-20-57</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>12-20-57</i>	9. AGE (In years last birthday) yrs. <i>8 yrs</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. <i>0 0 0 0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Fire Department</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James Edward BEAN</i>	14. MOTHER'S MAIDEN NAME <i>Mary Catherine BEAN</i>	Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>571-02-0000</i>	17. INFORMANT <i>Daughter</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>571.0</i>						
DUE TO <i>Inf</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Malnutrition</i>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Malnutrition</i>						
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month, Day, Year <i>9-15-57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata</i>	20f. (City or town) <i>La Plata</i>	(County) <i>La Plata</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>La Plata</i>						
ACTUAL SIGNATURE <i>E. J. E. ELEN</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>9-17-57</i>		
EXAMINER'S NAME (Type) <i>E. J. E. ELEN</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-15-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>New Town</i>	22d. LOCATION (City, town, or county) <i>La Plata</i>	(State) <i>Md</i>		
23. FUNERAL/DIRECTOR'S SIGNATURE <i>Richard Lee La Plata</i>	ADDRESS <i>2066287 XV5</i>	24a. REC'D BY REGISTRAR DATE <i>9/19/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Basye</i>			

RECEIVED

SEP 20 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

094126
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md b. COUNTY		Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac Heights		c. LENGTH OF STAY IN lb 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Potomac Heights		d. STREET ADDRESS 128 Tongueil Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Charles		O.	Billing Sley		11-23-00	56	19	57	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Mouths Days Hours Min.	
Male		White		11-23-00		56 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF, WHAT COUNTRY?			
Road Inspector		County Roads		Colonial Beach, Md.		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
James O. Billingsley		Susie Baker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		577-16-4489		Dr. Chas. O. Billingsley, Potomac Heights, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Coronary Occlusion				3 hours			
420.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)							
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Fracture right foot (2 wks old - reduced & cast applied)				19. WAS AUTOPSY PERFORMED?			
704.9						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour	a. m.	19	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>						
p. m.									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE		Frank A. Susan		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)		Frank A. Susan		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)			
Burial		9-21-1957		Oak Grove		Oak Grove, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Golant & Hartingly Wash D.C.		131-11182		OFP 09-19-57		Ody Puse			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU V. S.

SEP 20 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09413

9408

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH a. COUNTY WALDORF CHARLES	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND	b. COUNTY CHARLES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 1, Box 210	c. LENGTH OF STAY IN 1b 15 months	c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 1, Box 210 WALDORF x 2	d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) OSCAR James Bostwick	First OSCAR	Middle James	Last Bostwick	4. DATE OF DEATH Sept. 11 1957	Month Sept.	Day 11	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31 1898	9. AGE (In years, months, days) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist NAVAL GUN factory	10b. KIND OF BUSINESS OR INDUSTRY NAVAL GUN factory	11. BIRTHPLACE (State or foreign country) PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JAMES D. Bostwick	14. MOTHER'S MAIDEN NAME ADELIA COYKENDALL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) WORLD WAR I.	16. SOCIAL SECURITY NO. None	17. INFORMANT CLARENCE R Bostwick	Address 5816 ATMORE PL. WASH 71				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1							
DUE TO Coronary occlusion							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO coronary insufficiency							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1207 Nichols Ave	(County) 83
21. I certify that I attended the deceased from 1957 , 19, to 1957 , 19, that I last saw the deceased alive on 1957 , 19, and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. SCHWARTZMAN M.D. ADDRESS (Street, city or town, state) 1207 Nichols Ave DATE SIGNED 1957							
PHYSICIAN'S NAME (Type) A. SCHWARTZMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-16-57	22b. DATE THEREOF 9-16-57	22c. NAME OF CEMETERY OR CREMATORIUM ABLINGTON VA	22d. LOCATION (City, town, or county) ARLINGTON, VA	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home	ADDRESS 300-4 S. N.E. WASH. D.C.	24a. REC'D BY REGISTRAR 13 1957	24b. REGISTRAR'S SIGNATURE M. L. Monroe				
VS A15 (4) ISM 9/55							

27. **REQUERIMIENTO DE INGRESO AL ESTADO MAJESTAD**

RECEIVED SEP 13 1957 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09415
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Welcome Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Joyce Marie		First Cooper	Middle Last 4. DATE OF DEATH Sept 9/1957
5. SEX female	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9.1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George Vincent Riley		14. MOTHER'S MAIDEN NAME Mary Lucille Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT mother
		Address Welcome, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Respiratory collapse INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Pre mature separation of placenta 5 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) Pre mature labor.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE A. O. Woody, M. D.		M.D. La Plata, Md.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11-1957	22c. NAME OF CEMETERY OR CREMATORIAL Own Residence
22d. LOCATION (City, town, or county) (State) Belder Point Meeks			
23. FUNERAL DIRECTOR'S SIGNATURE Archibald Joe Taylor M.D.		24a. REC'D BY REGISTRAR DATE 9/16/57	24b. REGISTRAR'S SIGNATURE Julia H. Bassey
2066183 XVO			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

SEP 18 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09414

9410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55X
M 00
I

1. PLACE OF DEATH a. COUNTY		Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		a. STATE Md		
c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Charles		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Housiders		c. STREET ADDRESS		
COLBERT DENT		1		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		Last First Middle		4. DATE OF DEATH		
Dent		Colbert		9	Day 29 Year 1957	
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 12-1-04		9. AGE (in years 33 months 0 days)		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVAL Powder Factory		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		
13. FATHER'S NAME Thomas Dent		14. MOTHER'S MAIDEN NAME Anna		12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
				Colbert E Dent Housiders		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address				
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 981X		HEMORRHAGE				INTERVAL BETWEEN ONSET AND DEATH 4-29-57
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		GUNSHOT WOUND R+ Subclavian				
DUE TO (b)		Artery Severed				4-14-57
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		SHOT BY SON R+ GUN				
20c. TIME OF INJURY Month, Day, Year 1 p.m. 9-29 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) Housiders (County) (State) CHAS MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9-30-57
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4-1957		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope		22d. LOCATION (City, town, or county) Housiders (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE DEPARTMENT OF E. J. EDELEN MD.		ADDRESS 101157		24a. REC'D BY REGISTRAR DATE 10/1/57		24b. REGISTRAR'S SIGNATURE JULIA J. BARRY
Johnson - Denton 200-500 C.						

THE ATLANTIC STATE INSURANCE COMPANY - BOSTON, MASS.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 4 1957

REGELY EDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09416

9411

CERTIFICATE OF DEATH

Reg. Dist. No. 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b X2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Perry		First	Middle W.	Last Gilroy	4. DATE OF DEATH September 2 1957	Month September	Day 2	Year 1957	
S. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> January 22, 1876	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George Gilroy		14. MOTHER'S MAIDEN NAME Emily Anderson				Address Pauline M. Gilroy Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Cancer of the Prostate		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
						INTERVAL BETWEEN ONSET AND DEATH 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) La Plata		(County) Maryland	(State)
21. I certify that I attended the deceased from March 1957, to 2 Sept 1957, that I last saw the deceased alive on 2 Sept 1957, and that death occurred at 11:15 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick M. Johnson, M.D., La Plata, Maryland DATE SIGNED 23 Sept 57									
ACTUAL SIGNATURE Frederick M. Johnson, M.D.		PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-57		22c. NAME OF CEMETERY OR CREMATORIAL Burley Dokes		22d. LOCATION (City, town, or county) Pawtucket, Rhode Island		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick M. Johnson, M.D., La Plata, Maryland		ADDRESS 97757		24a. REC'D BY REGISTRAR DATE 9/7/57		24b. REGISTRAR'S SIGNATURE Julia H. Bassey			

CERTIFICATE OF DEATH

SEARCHED

BUREAU V.

SEP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09417

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G220 9-23-57 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Plains</i>	b. COUNTY <i>Charles</i>
c. LENGTH OF STAY IN 1b <i>2 weeks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Plains</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>	d. STREET ADDRESS <i></i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>JOHN</i>	Middle <i>ELWOOD</i>	Last <i>MARSHALL</i>	4. DATE OF DEATH Month <i>9</i>	Day <i>11</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-25-1891</i>	9. AGE (In years by birthday) <i>66</i> yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>

10a. USUAL OCCUPATION (Give kind of work done during best of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	--	---	---

13. FATHER'S NAME <i>Wm Henry Marshall</i>	14. MOTHER'S MAIDEN NAME <i>Mary Louise Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Henry Aubrey Marshall</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>9-11-57</i>
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>420.1</i>		<i>Cerebral Occlusion Probable</i>
Conditions, if any, which gave rise to immediate cause (b) (c)		
DUE TO		
DUE TO		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
--	--	--	--	--	--

ACTUAL SIGNATURE <i>E. J. Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9-12-57</i>
EXAMINER'S NAME (Type) <i>E. J. Edelen</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-16-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Joseph</i>	22d. LOCATION (City, town, or county) (State) <i>Pemberton</i>
---	-------------------------------------	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHNSON + JENNINGS WASH. D.C. MD.</i>	ADDRESS <i>4804 G.H. Ave.</i>	24a. REC'D BY REGISTRAR <i>Julia H. Pasen</i>	24b. REGISTRAR'S SIGNATURE <i>9/16/57</i>
--	----------------------------------	--	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF NEVADA - LAS VEGAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

SEP 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 221 10-23-57 a.m.s MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09418

Reg. Dist. No. 100

9413

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryanmoy		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Maryanmoy		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First BRENDA	Middle CAROL	Last MAY	
4. DATE OF DEATH	Month September	Day 18	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 9, 1957	
9. AGE (In years last birthday) yrs. 4	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 9	12. IF UNDER 24 HRS. Hours 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley May	14. MOTHER'S MAIDEN NAME Bettie Sidenstricker	Address Stanley May Maryanmoy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory infection with incipient bronchopneumonia</u> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE Russell S. Fisher	DATE SIGNED 9/18/57			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-120-57	22c. NAME OF CEMETERY OR CREMATORIAL Denterville	22d. LOCATION (City, town, or county) Denterville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Reholt Inc La Plata	ADDRESS 4000 257 XVO	24a. REC'D BY REGISTRAR DATE 9/24/57	24b. REGISTRAR'S SIGNATURE Julia H. Basye	

AMERICAN EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
SEP 26 1957

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

094190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>NC</i> b. COUNTY <i>Buncombe</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL <i>Bellingsay</i>)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ghelle 70x-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First <i>Clarence</i>	Middle <i>Lee</i>	Last <i>Maynard</i>	4. DATE OF DEATH <i>Sep 15 1957</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR FACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>10-18-1929</i>	9. AGE (In years last birthday) <i>28</i> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (State or foreign country) <i>Y.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Nettie Maynard</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>244-50-5397</i>		17. INFORMANT <i>Nettie Maynard</i>		Address <i>Cashville NC</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage</i>		<i>3 min.</i>
981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Epigastric Gunshot wound</i>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>5:30</i> p.m.		Month, Day, Year <i>SEPT 15 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>CHARLES, MD.</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>	
---	--

ACTUAL SIGNATURE <i>J.B. Dettor</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>SEPT. 17, 1957</i>
EXAMINER'S NAME (Type) <i>V.B. DETTOR MD.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>9-17-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Plaza Ma</i>	22d. LOCATION (City, town, or county) <i>Cashville Y.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Lee da Plazza Ma</i>		24a. REC'D BY REGISTRAR DATE <i>9/19/57</i>	24b. REGISTRAR'S SIGNATURE <i>Julia Massey</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrars for burial, cremation, or removal.

RECEIVED
BUREAU X. S.

SEP 5 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this 24 hours, the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this 72 hours, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9415

CERTIFICATE OF DEATH

09420

Reg. Dist. No. 102

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Charles Nanjemoy	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR. TOWN	02d Charles Nanjemoy
HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (in this place)		
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	4. DATE (Month) (Day) (Year) OF DEATH Sept 20 1957
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 9-20-57
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		IDB. KIND OF BUSINESS OR INDUSTRY	9. AGE first birthday yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME Archie Posey		11. BIRTHPLACE (State or foreign country) Nanjemoy - 02d	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		12. CITIZEN OF WHAT COUNTRY? 4-5.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Ordeelia Edynor	
17. INFORMANT & ADDRESS Archie Posey, Nanjemoy 02d			
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Prematurity (6 mo Premature) INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9/20, 1957, to 9/20, 1957, that I last saw the deceased alive on 9/20, 1957, and that death occurred at 9:30 A.M. from the causes and on the date stated above. SIGNATURE Frank G. Susan M.D. ADDRESS (Street, city, town, state) Indian Head Osp DATE SIGNED 9/20/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Sept 20 1957	NAME OF CEMETERY OR CREMATORIAL Mt. Hope	LOCATION (City, town, or county) (State) Bsondides Md.
24. REC'D BY REGISTRAR VS AISC-55 10W	REGISTRAR'S SIGNATURE W. Thompson	25. FUNERAL DIRECTOR'S SIGNATURE Archie Posey Nanjemoy Md.	
DATE Sept 20 1957			

4100369XV

61 STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
DIVISION OF INVESTIGATION
CERTIFICATE OF DEATH

DATE 1950-1959

SEARCHED INDEXED SERIALIZED FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU U.S.

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9416

CERTIFICATE OF DEATH

09421
Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nonjemoy</i>		c. LENGTH OF STAY IN 1b <i>XO</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Nonjemoy</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nonjemoy</i>	
d. STREET ADDRESS <i>Nonjemoy</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First <i>Robert</i>	Middle <i></i>
4. DATE OF DEATH <i>Sept 20 1957</i>		Lost <i></i>	Month <i>Sept</i> Day <i>20</i> Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-20-57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Nonjemoy, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Archie Possey</i>	14. MOTHER'S MAIDEN NAME <i>Merlelie Gaynor</i>	Address <i>Nonjemoy, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Archie Possey</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Prematurity (Due to Premature)</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i></i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i> (County) <i></i> (State) <i></i>
21. I certify that I attended the deceased from alive on <i>9/20</i> , 1957, to <i>9/20</i> , 1957, that I last saw the deceased and that death occurred at <i>5:05 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank A. Susan</i>	ADDRESS (Street, city or town, state) <i>Indian Head, Md.</i> DATE SIGNED <i>9/20/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 20/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Hope</i>	22d. LOCATION (City, town, or county) <i>Charles</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archie Possey Nonjemoy Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Sept 20 57 Dr. Thompson</i>
4200369 X V V			

CERTIFICATE OF DEATH

RECEIVED
BUREAU Y. S.
SEP 24 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 10a, 10b, 11, 12, F11mG221 10-11-57 et

10582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
CHARLES		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Charles	
Bural IRONSIDE Md.		X2 Transide		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
MALE		LEON	LORENZIA	ROSS	9 - 30 1957
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Coh.				AUG. 15 1917	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Construction Work		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES HARRISON ROSS		KATE DENT		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Address CHARLES HARRISON ROSS, Hilltop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 DAYS			
825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost.		INTRACRANIAL HEMORRHAGE			
(b) DUE TO BASAL SKULL FRACTURE		" "			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) AUTOMOBILE ACCIDENT			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 p. m. 9-27 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HILLTOP MD	
20f. (City or town) (County) Charles. (State) HILLTOP, MD.					
21. I certify that I attended the deceased from 9-27, 1957, to 9-30, 1957, that I last saw the deceased alive on 9-30-57, 1957, and that death occurred at 3:30 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) J. PARRAN JARBOE M.D. La Plata Md.			
ACTUAL SIGNATURE J. PARRAN JARBOE M.D.		DATE SIGNED 10-4-57			
PHYSICIAN'S NAME (Type) J. PARRAN JARBOE M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-4-57		22c. NAME OF CEMETERY OR CREMATORIAL LITTLE ZION	
22d. LOCATION (City, town, or county) HILLTOP, Charles, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE JOHNSON AND JENKINS 4804 Georgia Ave. N.W.		ADDRESS 10-11-57		24a. REC'D BY REGISTRAR 10-11-57	
				24b. REGISTRAR'S SIGNATURE MARY STRETHURST	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

OCT 3 1957

RECEIVED
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09422

9418

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ida Florence Rowe</i>		First <i>Ida</i>	Middle <i>Florence</i>
4. DATE OF DEATH <i>Sept 23 1957</i>		Last <i>Rowe</i>	Month <i>Sept</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 10 1891</i>
9. AGE (In years lost birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
10c. BIRTHPLACE (State or foreign country) <i>Canada</i>		11. CITIZEN OF WHAT COUNTRY? <i>Canada</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>C. A. Rowe</i>	
17. INFORMANT <i>C. A. Rowe</i>		Address <i>Waldorf, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, Spinal Cord</i>			
DUE TO <i>199.1</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma, Primary, Pelvic</i>			
DUE TO <i>Years</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>True</i> , 19 <i>40</i> to <i>Sept 23, 1957</i> , that I last saw the deceased alive on <i>Sept 18, 1957</i> , and that death occurred at <i>6:45 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Waldorf, Md.</i> DATE SIGNED <i>1957</i>	
ACTUAL SIGNATURE <i>George S. Weber, MD</i>		PHYSICIAN'S NAME (Type) <i>George S. Weber</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 25 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>Waldorf, Md</i>	
24a. REC'D BY REGISTRAR DATE <i>9/30/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Tollessey</i>	

BUREAU V. 5

OCT 2 1957

REGELIV FU

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09423

CERTIFICATE OF DEATH

9419

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY *Charles*
 CITY (If outside corporate limits, write RURAL
OR
and give nearest town)
 TOWN *Port Tobacco*

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS *Med.*

MARYLAND

LENGTH OF STAY
(In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE *Md.* COUNTY *Charles*
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN *Port Tobacco*
 STREET ADDRESS *1*

3. NAME OF
DECEASED
(Type or Print)

FEMALE

WHITE

(First) *omattie* (Middle) *D* (Last) *SIMPSON*6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

Feb 7, 1882 75

9. AGE last birthday

IF UNDER 1 YEAR
Months *0* Dey *0* Hours *0* Min. *0*

yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

14. MOTHER'S MAIDEN NAME

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

*William W. St. Clair**Ann S. Harach*INTERVAL BETWEEN
ONSET AND DEATH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

24 hours

(If Yes, give war or dates of service)

18. MEDICAL CERTIFICATION

420.0 IMMEDIATE CAUSE

(A)

*Myocardial Infarction*ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(B)

Arteriosclerotic Heart Disease

(C)

years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

M. 22. I hereby certify that I attended the deceased from *9 SEPT., 1957*, to *10 SEPT., 1957*, that I last saw the deceased
alive on *9 SEPT., 1957*, and that death occurred at *9:15 AM*, from the causes and on the date stated above.

SIGNATURE

Vernon S. Setters

ADDRESS (Street, city, town, state)

DATE SIGNED

*12 SEPT., 1957*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

Sept 12, 1957 St. Thomas

Chapel Point md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE *9/16/57*

Julia H. Pasey

Orehart Inc. Lodiating

SUREAU V. S.

SEP 18 1957

REGELIV E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
94 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0942400
 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

1
 M
 66
 I
 0
 ✓
 0
 08
 2
 2

1
 2
 3
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25
 26
 27
 28
 29
 30
 31
 32
 33
 34
 35
 36
 37
 38
 39
 40
 41
 42
 43
 44
 45
 46
 47
 48
 49
 50
 51
 52
 53
 54
 55
 56
 57
 58
 59
 60
 61
 62
 63
 64
 65
 66
 67
 68
 69
 70
 71
 72
 73
 74
 75
 76
 77
 78
 79
 80
 81
 82
 83
 84
 85
 86
 87
 88
 89
 90
 91
 92
 93
 94
 95
 96
 97
 98
 99
 100
 101
 102
 103
 104
 105
 106
 107
 108
 109
 110
 111
 112
 113
 114
 115
 116
 117
 118
 119
 120
 121
 122
 123
 124
 125
 126
 127
 128
 129
 130
 131
 132
 133
 134
 135
 136
 137
 138
 139
 140
 141
 142
 143
 144
 145
 146
 147
 148
 149
 150
 151
 152
 153
 154
 155
 156
 157
 158
 159
 160
 161
 162
 163
 164
 165
 166
 167
 168
 169
 170
 171
 172
 173
 174
 175
 176
 177
 178
 179
 180
 181
 182
 183
 184
 185
 186
 187
 188
 189
 190
 191
 192
 193
 194
 195
 196
 197
 198
 199
 200
 201
 202
 203
 204
 205
 206
 207
 208
 209
 210
 211
 212
 213
 214
 215
 216
 217
 218
 219
 220
 221
 222
 223
 224
 225
 226
 227
 228
 229
 230
 231
 232
 233
 234
 235
 236
 237
 238
 239
 240
 241
 242
 243
 244
 245
 246
 247
 248
 249
 250
 251
 252
 253
 254
 255
 256
 257
 258
 259
 260
 261
 262
 263
 264
 265
 266
 267
 268
 269
 270
 271
 272
 273
 274
 275
 276
 277
 278
 279
 280
 281
 282
 283
 284
 285
 286
 287
 288
 289
 290
 291
 292
 293
 294
 295
 296
 297
 298
 299
 300
 301
 302
 303
 304
 305
 306
 307
 308
 309
 310
 311
 312
 313
 314
 315
 316
 317
 318
 319
 320
 321
 322
 323
 324
 325
 326
 327
 328
 329
 330
 331
 332
 333
 334
 335
 336
 337
 338
 339
 340
 341
 342
 343
 344
 345
 346
 347
 348
 349
 350
 351
 352
 353
 354
 355
 356
 357
 358
 359
 360
 361
 362
 363
 364
 365
 366
 367
 368
 369
 370
 371
 372
 373
 374
 375
 376
 377
 378
 379
 380
 381
 382
 383
 384
 385
 386
 387
 388
 389
 390
 391
 392
 393
 394
 395
 396
 397
 398
 399
 400
 401
 402
 403
 404
 405
 406
 407
 408
 409
 410
 411
 412
 413
 414
 415
 416
 417
 418
 419
 420
 421
 422
 423
 424
 425
 426
 427
 428
 429
 430
 431
 432
 433
 434
 435
 436
 437
 438
 439
 440
 441
 442
 443
 444
 445
 446
 447
 448
 449
 4410
 4411
 4412
 4413
 4414
 4415
 4416
 4417
 4418
 4419
 4420
 4421
 4422
 4423
 4424
 4425
 4426
 4427
 4428
 4429
 44210
 44211
 44212
 44213
 44214
 44215
 44216
 44217
 44218
 44219
 44220
 44221
 44222
 44223
 44224
 44225
 44226
 44227
 44228
 44229
 44230
 44231
 44232
 44233
 44234
 44235
 44236
 44237
 44238
 44239
 44240
 44241
 44242
 44243
 44244
 44245
 44246
 44247
 44248
 44249
 44250
 44251
 44252
 44253
 44254
 44255
 44256
 44257
 44258
 44259
 44260
 44261
 44262
 44263
 44264
 44265
 44266
 44267
 44268
 44269
 44270
 44271
 44272
 44273
 44274
 44275
 44276
 44277
 44278
 44279
 44280
 44281
 44282
 44283
 44284
 44285
 44286
 44287
 44288
 44289
 44290
 44291
 44292
 44293
 44294
 44295
 44296
 44297
 44298
 44299
 442100
 442101
 442102
 442103
 442104
 442105
 442106
 442107
 442108
 442109
 442110
 442111
 442112
 442113
 442114
 442115
 442116
 442117
 442118
 442119
 442120
 442121
 442122
 442123
 442124
 442125
 442126
 442127
 442128
 442129
 442130
 442131
 442132
 442133
 442134
 442135
 442136
 442137
 442138
 442139
 442140
 442141
 442142
 442143
 442144
 442145
 442146
 442147
 442148
 442149
 442150
 442151
 442152
 442153
 442154
 442155
 442156
 442157
 442158
 442159
 442160
 442161
 442162
 442163
 442164
 442165
 442166
 442167
 442168
 442169
 442170
 442171
 442172
 442173
 442174
 442175
 442176
 442177
 442178
 442179
 442180
 442181
 442182
 442183
 442184
 442185
 442186
 442187
 442188
 442189
 442190
 442191
 442192
 442193
 442194
 442195
 442196
 442197
 442198
 442199
 442200
 442201
 442202
 442203
 442204
 442205
 442206
 442207
 442208
 442209
 442210
 442211
 442212
 442213
 442214
 442215
 442216
 442217
 442218
 442219
 442220
 442221
 442222
 442223
 442224
 442225
 442226
 442227
 442228
 442229
 442230
 442231
 442232
 442233
 442234
 442235
 442236
 442237
 442238
 442239
 442240
 442241
 442242
 442243
 442244
 442245
 442246
 442247
 442248
 442249
 442250
 442251
 442252
 442253
 442254
 442255
 442256
 442257
 442258
 442259
 442260
 442261
 442262
 442263
 442264
 442265
 442266
 442267
 442268
 442269
 442270
 442271
 442272
 442273
 442274
 442275
 442276
 442277
 442278
 442279
 442280
 442281
 442282
 442283
 442284
 442285
 442286
 442287
 442288
 442289
 442290
 442291
 442292
 442293
 442294
 442295
 442296
 442297
 442298
 442299
 442300
 442301
 442302
 442303
 442304
 442305
 442306
 442307
 442308
 442309
 442310
 442311
 442312
 442313
 442314
 442315
 442316
 442317
 442318
 442319
 442320
 442321
 442322
 442323
 442324
 442325
 442326
 442327
 442328
 442329
 442330
 442331
 442332
 442333
 442334
 442335
 442336
 442337
 442338
 442339
 442340
 442341
 442342
 442343
 442344
 442345
 442346
 442347
 442348
 442349
 442350
 442351
 442352
 442353
 442354
 442355
 442356
 442357
 442358
 442359
 442360
 442361
 442362
 442363
 442364
 442365
 442366
 442367
 442368
 442369
 442370
 442371
 442372
 442373
 442374
 442375
 442376
 442377
 442378
 442379
 442380
 442381
 442382
 442383
 442384
 442385
 442386
 442387
 442388
 442389
 442390
 442391
 442392
 442393
 442394
 442395
 442396
 442397
 442398
 442399
 442400
 442401
 442402
 442403
 442404
 442405
 442406
 442407
 442408
 442409
 442410
 442411
 442412
 442413
 442414
 442415
 442416
 442417
 442418
 442419
 442420
 442421
 442422
 442423
 442424
 442425
 442426
 442427
 442428
 442429
 442430
 442431
 442432
 442433
 442434
 442435
 442436
 442437
 442438
 442439
 442440
 442441
 442442
 442443
 442444
 442445
 442446
 442447
 442448
 442449
 442450
 442451
 442452
 442453
 442454
 442455
 442456
 442457
 442458
 442459
 442460
 442461
 442462
 442463
 442464
 442465
 442466
 442467
 442468
 442469
 442470
 442471
 442472
 442473
 442474
 442475
 442476
 442477
 442478
 442479
 442480
 442481
 442482
 442483
 442484
 442485
 442486
 442487
 442488
 442489
 442490
 442491
 442492
 442493
 442494
 442495
 442496
 442497
 442498
 442499
 442500
 442501
 442502
 442503
 442504
 442505
 442506
 442507
 442508
 442509
 442510
 442511
 442512
 442513
 442514
 442515
 442516
 442517
 442518
 442519
 442520
 442521
 442522
 442523
 442524
 442525
 442526
 442527
 442528
 442529
 442530
 442531
 442532
 442533
 442534
 442535
 442536
 442537
 442538
 442539
 442540
 442541
 442542
 442543
 442544
 442545
 442546
 442547
 442548
 442549
 442550
 442551
 442552
 442553
 442554
 442555
 442556
 442557
 442558
 442559
 442560
 442561
 442562
 442563
 442564
 442565
 442566
 442567
 442568
 442569
 442570
 442571
 442572
 442573
 442574
 442575
 442576
 442577
 442578
 442579
 442580
 442581
 442582
 442583
 442584
 442585
 442586
 442587
 442588
 442589
 442590
 442591
 442592
 442593
 442594
 442595
 442596
 442597
 442598
 442599
 442600
 442601
 442602
 442603
 442604
 442605
 442606
 442607
 442608
 442609
 442610
 442611
 442612
 442613
 442614
 442615
 442616
 442617
 442618
 442619
 442620
 442621
 442622
 442623
 442624
 442625
 442626
 442627
 442628
 442629
 442630
 442631
 442632
 442633
 442634
 442635
 442636
 442637
 442638
 442639
 442640
 442641
 442642
 442643
 442644
 442645
 442646
 442647
 442648
 442649
 442650
 442651
 442652
 442653
 442654
 442655
 442656
 442657
 442658
 442659
 442660
 442661
 442662
 442663
 442664
 442665
 442666
 442667
 442668
 442669
 442670
 442671
 442672
 442673
 442674
 442675
 442676
 442677
 442678
 442679
 442680
 442681
 442682
 442683
 442684
 442685
 442686
 442687
 442688
 442689
 442690
 442691
 442692
 442693
 442694
 442695
 442696
 442697
 442698
 442699
 442700
 442701
 442702
 442703
 442704
 442705
 442706
 442707
 442708
 442709
 442710
 442711
 442712
 442713
 442714
 442715
 442716
 442717
 442718
 442719
 442720
 442721
 442722
 442723
 442724
 442725
 442726
 442727
 442728
 442729
 442730
 442731
 442732
 442733
 442734
 442735
 442736
 442737
 442738
 442739
 442740
 442741
 442742
 442743
 442744
 442745
 442746
 442747
 442748
 442749
 442750
 442751
 442752
 442753
 442754
 442755
 442756
 442757
 442758
 442759
 442760
 442761
 442762
 442763
 442764
 442765
 442766
 442767
 442768
 442769
 442770
 442771
 442772
 442773
 442774
 442775
 442776
 442777
 442778
 442779
 442780
 442781
 442782
 442783
 442784
 442785
 442786
 442787
 442788
 442789
 442790
 442791
 442792
 442793
 442794
 442795
 442796
 442797
 442798
 442799
 442800
 442801
 442802
 442803
 442804
 442805
 442806
 442807
 442808
 442809
 442810
 442811
 442812
 442813
 442814
 442815
 442816
 442817
 442818
 442819
 442820
 442821
 442822
 442823
 442824
 442825
 442826
 442827
 442828
 442829
 442830
 442831
 442832
 442833
 442834
 442835
 442836
 442837
 442838
 442839
 442840
 442841
 442842
 442843
 442844
 442845
 442846
 442847
 442848
 442849
 442850
 442851
 442852
 442853
 442854
 442855
 442856
 442857
 442858
 442859
 442860
 442861
 442862
 442863
 442864
 442865
 442866
 442867
 442868
 442869
 442870
 442871
 442872
 442873
 442874
 442875
 442876
 442877
 442878
 442879
 442880
 442881
 442882
 442883
 442884
 442885
 442886
 442887
 442888
 442889
 442890
 442891
 4

DEPARTMENT OF HEALTH-EDUCATION-WEAVER

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 4 1957

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
9421

09425
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		c. LENGTH OF STAY IN 1b ✓ 3 1/2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md		d. STREET ADDRESS ✓ Catholic Rectory Mattingly Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS ✓ Catholic Rectory Mattingly Ave.		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Snick Sweeney		John	Thomas	(SWEENEY)	9-8-57			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	W-US	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	May 30, 1910	✓ 47 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest.		10b. KIND OF BUSINESS OR INDUSTRY Roman Cath. Ch.		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Michael Sweeney		14. MOTHER'S MAIDEN NAME ✓ Anna Clinton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Owen E. Sweeney-Balt., Md.		Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		Immediate	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u>		Indefinite	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
---	--	--	--	--	--

ACTUAL SIGNATURE James E. Andrews		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9-8-57
EXAMINER'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/11/57	22c. NAME OF CEMETERY New Cathedral	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.	ADDRESS 317 Pa. Ave., SE DC3	24a. REC'D BY REGISTRAR Odey Grace	24b. REGISTRAR'S SIGNATURE Odey Grace

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar, prior to burial or removal.

RECEIVED
BUREAU X

SEP 10 1957

1
FOR STATE
HEALTH DEPT.
N

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09426

Reg. Dist. No.

105

18:G220 9-25-57L Item 10 Film 221 10-7-57 ams

9422

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE PLAINS		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 White Plains			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							

3. NAME OF DECEASED (Type or print)	First MILTON	Middle W.	Last SYDOR	4. DATE OF DEATH	Month September	Doy 4	Year 1957
--	-----------------	--------------	---------------	------------------	--------------------	----------	--------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 17, 1938	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
----------------	---------------------------	---	-------------------------------------	---	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Washington DC.	12. CITIZEN OF WHAT COUNTRY? US.
--	--	---	-------------------------------------

13. FATHER'S NAME Samuel Sydnor	14. MOTHER'S MAIDEN NAME Leslie Montgomery	Address
------------------------------------	---	---------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215 36 5633	17. INFORMANT Samuel Sydnor	White Plains Md.
---	--	--------------------------------	------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 401.3 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
--	--	--	--	--	--	--	--	-------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	--	--	--	--	--	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE <i>Paul F. Guerin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9/5/57
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 3 1957	22c. NAME OF CEMETERY OR CREMATORIAL Church of God	22d. LOCATION (City, town, or county) Baltimore Md (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>	ADDRESS Walney	24a. REG. NO. BY REGISTRAR 10105	24b. REGISTRAR'S SIGNATURE D. L. Monroe
		DATE SEP 10 1957	

MANUFACTURED BY THE STATE OF HAWAII - DIVISION OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU V. S.

SEP 10 1957

RECEIVED

INVESTIGATOR

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 FilmG221 10-16-57 et

0942700
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5012 5th St NW 47X-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS <i>Wash DC.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Douglas</i>	Middle <i>Durant</i>	Last <i>Williams, Jr.</i>
4. DATE OF DEATH Month <i>SEPT.</i>	Day <i>28</i>	Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2 FEB. 1931</i>
9. AGE (In years last birthday) <i>26 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Auto Repair</i>	11. BIRTHPLACE (State or foreign country) <i>W. Va Schools L. C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Douglas D. Williams</i>	14. MOTHER'S MAIDEN NAME <i>Louise Williams</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>249-44-4383</i>	17. INFORMANT <i>Mrs D. Boyce</i>	INTERVAL BETWEEN ONSET AND DEATH <i>0</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage and Multiple Skull Fractures</i>			
825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Trauma - Auto Accident</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>Auto accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>9-28</i> 19 <i>57</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>
20f. (City or town) <i>Highway</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Vernon B. Dettor</i>	DATE SIGNED <i>28 SEPT. 1957</i>		
EXAMINER'S NAME (Type) <i>VERNON B. DETTOR</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 28 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethesda Ad Memorial Cemetery Washington D.C.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert McSapler Jr. M.D.</i>	ADDRESS <i>1001 15th St NW</i>	24a. REC'D BY REGISTRAR <i>Julia H. Basye</i>	24b. REGISTRAR'S SIGNATURE
DATE <i>10/1/57</i>		DATE <i>10/1/57</i>	

WELDING EXAMINER'S CERTIFICATE OF DEATH
STATE DEPARTMENT OF HEALTH - BUREAU 19

NAME

BUREAU V. S.

OCT 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 094280

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Faulkner		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)		First PERE	Middle WILMER	Lost	4. DATE OF DEATH SEPT 18 1957	Month	Day	Year
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1892	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Govt.		10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PERE WILMER		14. MOTHER'S MAIDEN NAME AMELIA MATTHEWS		Address Mrs. F. Hill Hamilton LA PLATA, MD.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. F. Hill Hamilton		INTERVAL BETWEEN ONSET AND DEATH 1 mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Respiratory collapse.				9 mo.		
(b) DUE TO Metastatic carcinoma, generalized						1 year.		
(c) DUE TO Prostatic carcinoma								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) La Plata		(County) (State)
21. I certify that I attended the deceased from <u>June 1949</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>18 Sept</u> , 19 <u>57</u> , and that death occurred at <u>3:05 AM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 18 Sept 57		
ACTUAL SIGNATURE <u>Arthur O. Wooldy</u>		M.D.						
PHYSICIAN'S NAME (Type) ARTHUR O. WOOLDDY								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-57		22c. NAME OF CEMETERY OR CREMATORIAL Mt Rest		22d. LOCATION (City, town, or county) La Plata, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORF, MD		24a. REC'D BY REGISTRAR DATE 9/23/57		24b. REGISTRAR'S SIGNATURE Julia D. Pasey		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 25 1957

BUREAU V. 3

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9425 CERTIFICATE OF DEATH

109429-00
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. LENGTH OF STAY IN 1b RURAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John C. Woodland		e. STREET ADDRESS XO Hughesville		d. STREET ADDRESS XO Hughesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John C. Woodland		First	Middle	Lost	4. DATE OF DEATH Sept 20	Month	Day	Year	1957		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 2, 1893	9. AGE (In years lost birthday) yrs. 64	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME Joseph Woodland	14. MOTHER'S MAIDEN NAME Anna ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT James E. Woodland		Address Hughesville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-Vascular Renal Disease DUE TO (c) —										INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. p.m. 19		Month, Day, Year —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bryantown		(County) —	(State) Md.	
21. I certify that I attended the deceased from Sept 1, 1957 , to Sept 1, 1957 , that I last saw the deceased alive on Sept 15, 1957 , and that death occurred at M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Bryantown, Md.	DATE SIGNED Richard N. Dobson
ACTUAL SIGNATURE Richard N. Dobson		PHYSICIAN'S NAME (Type) Richard N. Dobson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cem.		22d. LOCATION (City, town, or county) Bryantown, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.									
24a. REC'D BY REGISTRAR Julia N. Passey		24b. REGISTRAR'S SIGNATURE									
DATE 9/23/57											

